MAINE HEALTH CARE REFORM COMMISSION

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November, 1995

To All Those Interested in Health System Reform:

It is my pleasure to present the Maine Health Care Reform Commission's Final Report, *Recommendations For Health System Reform.* This report describes three approaches to reforming Maine's health system. These approaches include the implementation of a single payer model of financing care that offers coverage to all citizens of the State, and, alternatively, the implementation of a multiple payer system also offering universal access to coverage. The third approach represents incremental reform, focusing on market improvements and an expansion of coverage to Maine's most vulnerable citizens and most important resource -- our children.

Further, we present our recommendations for a statewide health information system for Maine. This initiative is fundamental to any reform; without adequate and reliable data, policy makers will be unable to evaluate the impact of reforms or to design strategies to most effectively address the problems of the health care system.

Finally, we offer specific proposals for improving public health in Maine, for a comprehensive quality assurance and improvement effort, and for facilitating improvements in health professionals workforce and education planning. We also suggest specific evaluation activities in the area of medical liability reforms.

Our final recommendations are based on the draft proposals which we issued earlier this year and on the comments on the draft proposals that we received during the public comment period. Many of the draft recommendations appear in this Final Report relatively unchanged. However, our recommendations for incremental reform have been modified substantially. The character of the purchasing alliance has been altered, but it still allows for an effective aggregate of purchasers which, in turn, should make affordable insurance coverage available to a greater number of people. We have also included a number of additional market reforms which we feel are necessary to improve the functioning of the health insurance market.

In our draft recommendations we proposed fundamental reforms related to medical liability. We had been interested in attempting to improve the medical liability system for consumers, and our proposal had been presented in that spirit. However, based on the many

comments we received voicing opposition to those recommendations, it appears that continued advocacy of that proposal would not contribute positively to the debate on medical liability. We have therefore decided to withdraw the recommendation.

The Final Report represents the culmination of an incredible effort by many dedicated people. The Commission and its staff acknowledge the hard work of the Commission's many advisory committee members -- this report would not have been possible without them. We also thank the many people who took the time to attend our meetings, to review the draft recommendations and who offered constructive suggestions about them. With their assistance and consideration, we feel that we have developed models for health reform that reflect the needs and preferences of Maine citizens. Assistance provided by other state agencies as well as our consultants has been invaluable as well.

We also acknowledge the generous assistance of the Robert Wood Johnson Foundation and the Commonwealth Fund which provided substantial financial support for the Commission's work. The recommendations, however, are the Commission's own and in no way represent the views of our funders, their directors, officers or staff.

In January, 1996 we will be submitting proposed legislation for each of the major initiatives presented in the Final Report. We look forward to working with the Legislature on these proposals and to an improved health system for Maine.

Sincerely,

Robert B. Keller, M.D.
Chairman
for the Commission

MAINE HEALTH CARE REFORM COMMISSION

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PRINTED UNDER APPROPRIATION NO. 010 30A 1125 012

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Introduction

In 1994, the Maine Legislature established the Maine Health Care Reform Commission and assigned it the task of designing at least three proposals for changing Maine's present health care system. The Commission was mandated to offer:

- a single-payer universal coverage bill;
- a multiple-payer universal coverage bill; and
- incremental reforms to the existing system, emphasizing cost containment, managed care and improved access;
- a standard benefit package, used to estimate cost for each reform model;
- a proposal for a uniform health care data system.

In addition to the required recommendations, the Commission is making other recommendations for reforming health care in Maine.

- A quality assessment program to measure the outcomes and efficacy of health care procedures relative to their cost;
- A strategy to improve public health in Maine, to be funded by an increase in taxes on tobacco products;
- The creation of a health workforce forum to better coordinate workforce education and planning;
- A study of the pre-litigation screening panels for medical malpractice, to be designed and commissioned by the Bureau of Insurance;
- A commission to study the cost-effectiveness of the mandated benefits, reporting back to the Legislature for adoption or rejection of the commission's findings;
- Recommendations to the State's Congressional delegation for modifications to the federal ERISA statute.

Using a Washington, D.C. consulting firm, Health Systems Research, Inc., actuaries from the accounting firm of Coopers & Lybrand, L.L.P., and with the help of Maine's State Planning Office, the Commission has estimated not only the cost of the three plans, but also the means of paying for them and their specific effect on the economy of the State.

As a result of this analysis, one conclusion has become inescapable: any attempt to establish universal health care through the resources of the State alone, cannot be accomplished without putting Maine at a significant economic disadvantage *vis à vis* other states. For both a single-payer and a multiple-payer universal plan, taxes would have to be raised significantly. In addition, federal law, particularly the ERISA statute, does not allow states to mandate coverage for those of its citizens who are under self-insured company plans.

Based on these findings the Commission concludes that an individual state cannot implement universal coverage by itself. While states can play a critical role, universal coverage must be initiated and supported at the federal level.

Although the Commission does not believe universal coverage possible at this time, it will present legislation for both a single-payer and a multiple-payer universal coverage system, in accordance with our legislative mandate. We believe the principle of universal coverage is an all-important goal and that the mechanisms for accomplishing it, as designed by this Commission, can serve as models for future action.

The third, incremental, model of health reform, will not achieve universal coverage. However, the incremental measures recommended are important steps toward expanding coverage and containing costs.

Below summarizes each of the Commission's recommendations.

Standard Benefit Package

As directed by the Legislature, the Maine Health Care Reform Commission, with guidance from its advisory committees, developed a standard benefit package to be used for estimating the cost and economic impact of each of the three alternative proposals for reform.

The Commission has incorporated this benefit package as the standard package for both of the universal plans. The incremental plan does not prescribe a standard benefit package, although the Commission endorses this benefit package as a model for comprehensive health benefit coverage.

The benefit package:

- Covers a broad range of services. It is similar to the State Employees Health Insurance Plan and other comprehensive plans. However, it covers more services than many of the plans currently available to consumers.

- Includes services felt to be essential for meeting the health care needs of Maine's citizens. In addition to covering most medical services, basic preventive dental health care, and prescription drugs, this benefit design emphasizes preventive care, education and wellness.

- Incorporates mental health and substance abuse services at full parity with other medical services through a managed care model.

The Single-Payer Plan with Universal Coverage

As required by its enabling statute, the Commission has developed a single-payer model that is similar, but not identical to, the Canadian system.

The economic analysis of the single-payer plan illustrates that, in the absence of meaningful national reform, this system, of the three reform options considered, would have the most significant negative impact on Maine's economy. This impact is measured in terms of employment, Gross State Product, and *per capita* income. In addition, as discussed elsewhere, federal law limits the State's ability to implement a single-payer model. Federal action to eliminate these barriers is unlikely at this time. For that reason the Commission believes that implementation of this plan is economically, legally, and politically untenable on an individual state level.

If Maine were to implement a single-payer plan, the Commission recommends the following design:

- All persons will be covered by the standard benefit package recommended by the Commission.

- There will be no copayments or deductibles for medical services and modest copayments for prescription drugs.

- A private entity will administer the single-payer plan with oversight by the new Maine Health Care Authority, an independent state agency modeled after the Public Utilities Commission.

- The Maine Health Care Authority will set the global budget and will coordinate a proactive health planning process to include workforce planning, diffusion of technology and capital investments.

- Instead of health insurance premiums and out-of-pocket payments, the single-payer system will be financed by broad based tax increases. Personal income taxes will triple to 10.5 percent. Corporate taxes will more than double with a new 5 percent payroll tax and an increase in the corporate tax rate to 14.25 percent. "Sin taxes" will double and the sales tax will increase by 1 percent.

The Multiple-Payer Plan with Universal Coverage

The second reform option developed by the Commission is a multiple-payer model. The multiple-payer model employs the concept of "managed competition" to achieve the highest quality care at the lowest possible cost. Like the single-payer model, this option assumes that the federal ERISA statute will be reformed, in this case to enable the State to mandate that self-insured employers provide and pay for 50 percent of the cost of health care coverage for all employees. Given the current national political climate, it is unlikely that ERISA will be changed to support this type of reform initiative.

The economic modeling illustrates the problems Maine would face if it tried to "go it alone" to achieve universal coverage. This model has a significant negative economic impact on the State when measured in terms of the employment rate, gross domestic product and *per capita* income levels. Because of the impediments imposed by ERISA and the economic impact, the Commission believe the multiple-payer model is not a viable option at this time.

If Maine were to implement a multiple-payer plan at this time, the Commission recommends the following design:

- All persons will be covered by the standard benefit package recommended by the Commission.

- Copayments and deductibles would apply. In fee-for-service plans, after a $500 per person annual deductible is satisfied, coverage will be provided with a 20 percent patient copayment. Annual out-of-pocket expenditures for individuals will be limited to $1,500. Managed care products will have a $10 office visit copayment and a copayment required for inpatient hospital stays.

- Consumers will have a choice of at least one fee-for-service and one managed care plan.

- An Alliance will administer the day-to-day operation of the multiple-payer system. The Alliance will negotiate with health plans, enroll participants, collect and distribute premium payments and subsidies, and monitor the quality and outcomes of care.

- The Alliance will be part of an independent state agency, to be called the Maine Health Care Authority. The Authority will set an annual global health care budget for the State and will coordinate a proactive health care planning process to include workforce issues, diffusion of technology and capital investments.

- The system will be financed by evenly splitting the premium (50/50) between the employer and the employee.

- Premium subsidies will be given to individuals up to 250 percent of the federal poverty line and to businesses with health care premium contributions exceeding 7.5 percent of payroll. The subsidies will be funded by broad based tax increases including an increase in the personal income tax from an effective rate of 3.5 percent to 4.3 percent (dropping to 4 percent in the year 2002), a new payroll tax of 2.25 percent (falling to 1.25 percent in the year 2002), a 1 percentage point increase in the sales and meals taxes (falling to a .5 percentage point increase in the year 2002), a 100 percent increase in "sin taxes" on tobacco and alcohol, and an extension of the application of a "premium tax" to those health insurance plans currently exempt from that tax.

The Incremental Reform Model

While the Commission believes that universal coverage is unobtainable at this time, the Commission also believes that there are several steps the State can take to improve the health care system in Maine. The third model of reform, the incremental model, does not provide for universal coverage. However, we believe these incremental measures can increase access, stimulate the use of managed care and conserve costs by maximizing administrative efficiencies and increasing the purchasing power of the State, small businesses, and individuals.

There are two main features of the Commission's incremental reforms. The first is the creation of a voluntary community purchasing alliance which will negotiate the purchase of health insurance jointly with the State Employees Health Commission (SEHC). The second is an expansion of the Medicaid program to cover children up to 250 percent of poverty. These proposals are summarized below.

The Community Alliance and State Employees Health Commission

The Commission believes that Maine's employers, individuals and state employees will benefit if they join forces to buy health insurance. At the same time, the Commission recognizes that state employees and other members of the community may wish to retain control over their own health insurance program. For that reason, the Commission proposes that Maine create a Community Alliance to purchase health insurance on behalf of employers and individuals. The State Employees Health

Commission will continue to purchase health insurance on behalf of state employees. The two groups will join their respective bargaining power to negotiate price with bidding health plans.

i. The Community Alliance

- The Community Alliance will:
  - Lower health insurance costs for Alliance members and state employees because of joined bargaining power;
  - Maximize administrative efficiency for small employers and individuals;
  - Allow employers to offer employees a wide range of health plans rather than just one.
- The Community Alliance will purchase health insurance on behalf of employers and individuals.
  - The Community Alliance will be a public, non-profit corporation governed by a board.
  - The first board of the Community Alliance will be appointed by the Governor. All subsequent boards will be elected by Community Alliance members.
  - The public will retain oversight through an annual audit submitted to the Legislature, the Governor and the State Auditor.
- The Community Alliance membership will be in separate risk pools.
  - There will be a separate pool for small businesses and for individuals.
  - After three years the Community Alliance will consider whether or not to merge the risk pools.
- The Community Alliance will provide a number of services:
  - Marketing selected plans;
  - Enrolling participants;

- Approving marketing materials offered by plans;
- Collecting premiums from participants;
- Forwarding premium payments to the plans;
- Conducting quality oversight;
- Providing ombudsman services to consumers;
- Applying a risk-adjustment process to correct for adverse selection.

ii. The joint bargaining power of the Community Alliance and the SEHC

- The Community Alliance will purchase health insurance jointly with state employees.
  - The board of the Community Alliance and the SEHC will each be responsible for designing the benefit packages that will be offered to their own membership.
  - Carriers must offer health insurance to both state employees and members of the Community Alliance if they want to participate.
  - Each board will assign two representatives to a joint negotiating committee that will solicit and negotiate bids with interested health plans.
  - Both the Community Alliance board and the SEHC, not the joint negotiating committee, will retain ultimate authority to accept or reject the final bid package.

iii. Necessary market reforms

- To minimize adverse selection, the health insurance market rules must be the same both inside and outside the Community Alliance. The Commission recommends, therefore, that small group reforms such as community rating, guaranteed issue and renewal be expanded to include groups of 25 to 99 employees.
- Also to avoid adverse selection, purchasers of health insurance need to know about all of their options. Insurance agents and brokers, therefore, will be required to disclose all products that they sell. They will also be required to disclose their fees.

Expanding Medicaid for children up to 250 percent of poverty

- The Commission recommends that Maine expand its Medicaid program to cover children under age 19, up to 250 percent of the federal poverty level. The State can make this expansion without applying for a waiver from the federal government.

- This Medicaid expansion will extend Medicaid coverage to an estimated 25,000 children. Preliminary experience in Minnesota suggests that parents may find it easier to leave welfare programs if their children have health insurance.

Other reforms

- The Department of Human Services (DHS) will be required to develop a State Health Plan based on the best available data. DHS will update that plan on a biennial basis.

- The Certificate of Need (CON) Program will be maintained in its current form. The Department of Human Services will coordinate the State Health Plan with the CON process so that the CON standards may be applied proactively.

- All employers will be required to offer payroll deduction for employees to purchase health insurance, although they will not be required to pay for that benefit.

- A new commission will be appointed to evaluate the mandated health insurance benefits currently required by statute. This commission will determine, to the extent possible, whether these mandates are cost-effective or otherwise justified. The Legislature will accept or reject the commission's findings in whole.

- Disclosure requirements, and other patient and provider protections will be imposed on health plans.

- The tax exempt status for non-profit health insurers will be eliminated. Because of market reforms regulating the conduct of both for-profit and non-profit health insurers, the tax exempt status is no longer justified.

Financing

- Elimination of the tax exempt status for non-profit health insurers and HMOs will fund the incremental package. An estimated $8 million will be needed to fund the Medicaid expansion. The remainder, at least in the first year of the alliance's existence, will provide start-up funds for the alliance.

A New Health Information System

The Legislature directed the Commission to develop recommendations for a health information system. Compared to many states, Maine has a very good data system, but many components of an ideal information system are missing. As the Legislature recognized, health data are critical to understanding and analyzing the three critical components of health care -- access, cost and quality. We consider the development of the Maine Health Data Organization (MHDO) to be one of our most important recommendations.

- The Maine Health Data Organization will be an independent, state agency, governed by a board composed of both public and private sector stakeholders.
- Data on utilization, including costs and charges should be reported by all providers of services.
    - Facilities and providers currently required to provide data should continue to do so.
    - The MHDO will develop a plan for requiring other providers to also supply these data.
    - The MHDO will work with providers to establish a reasonable and workable implementation plan.
    - Pharmaceutical data will be collected on a statewide basis.
- Population surveys will collect data relevant to:
    - Health care quality, outcomes and satisfaction;
    - Access to care, including insurance coverage;
    - Health status, health risk behaviors, and the economic impact of poor physical and emotional health.

- The MHDO will work with licensing boards and agencies to coordinate and improve the data collected by those agencies.

- Initially, the hospital assessment currently funding the data collection activities of the Maine Health Care Finance Commission will be continued as funding for the MHDO. After just a few years, the MHDO will become self-supporting by charging user fees or obtaining other sources of funding.

Public Health

The Commission believes that preventive health care, through an effective public health program, is essential to the quality of life in Maine.

Maine currently devotes less than 1 percent of total health care spending to public health, and our match of federal dollars is one of the lowest in the nation. This minimal emphasis on prevention coincides with significant health expenditures to treat preventable disease. Smoking-related illnesses alone cost the State $257 million annually.

For all three models, the Commission recommends an increase in the amount of financial support for public health:

- The Commission recommends that public health spending be increased to approximately 3 percent of health care costs, a public health spending level consistent with that recommended by leading health care authorities.

- For the incremental model, funding for the public health measure is, in and of itself, a public health measure. Finances will be raised by increasing the tax on cigarettes to $1 and by increasing the tax on other tobacco products by 200 percent. *Because raising the cost of tobacco products will deter teenage smoking, the Commission believes that making tobacco products more expensive is, in and of itself, a public health measure.* (In the universal coverage models, funding is built into the broad based financing design.)

- The public health funds will be used to develop a comprehensive strategic plan to improve the health status of Maine's population. The strategic plan will be based on a survey designed to determine Maine's current performance in the core areas of public health. The actual expenditure of funds will be based on comprehensive and rigorous application of cost/benefit analysis and justification on a program by program basis.

Quality Assurance

While the cost of health care is of great importance, the quality of care should be the highest priority. A health care market based on competition has spread across the

nation and is rapidly developing in Maine. The competitive market inevitably stresses cost reduction as its major feature. The Commission believes it essential that the State ensure a counterbalancing emphasis on quality.

The Commission believes that it is possible to conserve costs and improve quality through the development of quality assurance programs. To support these efforts, a high quality health information system will be required. In addition, the Commission recommends three separate approaches to quality measurement, assurance and improvement:

- Health plans should provide "report cards," containing standardized reports of quality and access. The reports should be subject to external audits. These report cards will help consumers make informed health care purchasing decisions.

- A Quality Improvement Foundation (QIF) should be designated in the State. The QIF will work with the provider community on a wide range of data analyses, continuing education, outcomes research and rural provider support.

- Depending on which of the three models, the Alliance or another administrative body should conduct "quality performance reports" on the quality of care plan participants receive.

Medical Liability Reform

The Commission has made a number of findings regarding the medical liability system. We believe that the current tort-based system fails to compensate many patients who sustain injuries while sometimes providing excessive awards to others. Defensive medical practices and high transaction costs increase the overall cost of medical care with only 30 percent of the malpractice premium dollars being returned to patients. Because it is based on the concept of "fault," the present system inhibits physicians and hospitals from participating in research and educational activities that would potentially decrease the rate of injury and encourage prompt settlement when they occur.

In its draft recommendations, the Commission proposed an "early-offer" model of liability reform. Under this model, an offer of settlement for economic damages by a provider within 180 days of an adverse event would preclude recovery of non-economic damages. In recommending this concept, the Commission hoped that there would be broad public interest in a liability system which had the potential to provide compensation to injured persons without the long delay, high transaction costs and uncertainty of the current tort system. However, the generally negative response to our proposal has lead us to conclude that our proposal will not contribute to the ongoing debate over medical liability in a useful way. The Commission has decided, therefore, to withdraw the "early offer" proposal from its Final Report.

In response to many comments and suggestions about the pre-litigation screening panels, the Commission recommends that the Bureau of Insurance be charged with the duty of assessing their success. The Bureau will be required to collect data on the screening panels and commission an unbiased, scientific evaluation of their performance.

The Commission also recommends the development of information and quality improvement programs that would encourage the health system to develop programs of prevention and continuous quality improvement to address issues of medical injury and liability.

Workforce Planning

The ability to pay for health care does not assure access to health care providers. A shortage of health care professionals in rural areas may mean that rural residents are deprived of needed services. At the same time, an oversupply of health professionals can produce upward pressure on cost. The Commission believes Maine suffers from an inappropriate distribution of its health professionals: some urban areas have an oversupply while many rural areas suffer from a shortage of health professionals.

The Commission believes that Maine should do a better job at coordinating the supply of health professionals. The Commission recommends that the Commissioner of the Department of Human Services convene a Healthcare Workforce Forum to discuss health workforce planning. The forum would:

- include participants from a broad range of health professions and educational programs;
- serve as a clearinghouse of information gathered through the process, creating a single access point for anyone interested in workforce issues;
- develop an inventory of the present health workforce and educational programs in the State;
- develop research and analytic methods for understanding population-based needs on an ongoing basis;
- consider the usefulness of forming a "federation" of licensing boards to facilitate communication across medical disciplines;
- provide a foundation for assisting stakeholders to make appropriate decisions about the best use of health care personnel in Maine and the need for health education.

ERISA

It is clear that without national reform of the Employee Retirement Income Security Act (ERISA), states are unable to implement universal coverage. Self-insured companies (employing as much as 50 percent of the total insured population) are exempt from state regulation and control. The following are recommended changes to ERISA that preserve those features of the Act that are most important to businesses (i.e. administrative simplicity for multi-state employers) while giving states more flexibility in reforming the health care marketplace. These recommendations will be forwarded to Maine's Congressional delegation for consideration and action.

- The ERISA statute should require a standard "minimum benefit package" that includes preventive care, guaranteed insurance portability and eliminates pre-existing condition limitations.

- ERISA should require self-insured companies to participate in data collection efforts, on both a state and federal level. Standards should be set for uniform requirements and a standardized claims form.

- ERISA should establish more rigorous consumer protections, including an improved grievance procedure.

- States should be given limited authority to tax ERISA plans, to the same extent other insurers are taxed (currently a 2 percent premium tax), to help finance extensions of coverage to the uninsured.

Conclusion

This Commission believes strongly that all Maine citizens should have access to health care. This belief is based on both humanitarian and practical considerations. Not only is access to health care essential to the quality of life for Maine's citizens, it is only with universal coverage will we be able to understand and address cost-containment and quality assurance. It is therefore with considerable reluctance that the Commission concludes that universal coverage is unobtainable in Maine without assistance from the federal government. We believe that the incremental measures recommended here will improve access to health care in this State. However, we call upon the federal government to provide coverage for those who fall through the cracks. We hope that all Maine citizens will join in that call.